immunity does not apply. The exclusions, by definition, apply even if the hospital reasonably believed that the forms of conduct adversely affected patient welfare. Put differently, HCQIA does not grant hospitals immunity if they use their control over admitting privileges to prevent physician collaboration with other types of health care providers or for engaging in other competitive conduct.

The Third Circuit ruled below that whether Petitioner's actions were intended to solicit or retain business under § 11151(9) was irrelevant because:

> even when the solicitation exception is in play, immunity will be judged by . . . whether the Hospital based its actions upon the reasonable belief that they are in furtherance of quality healthcare.

Pet. App. 31-32. Thus, according to the Third Circuit, whenever a hospital has a "reasonable belief" that it is furthering quality health care, the stated exceptions to immunity in § 11115 do not apply and the hospital is still entitled to immunity.

This conclusion is inconsistent with the plain language of § 11151(9) and reads all of the exceptions out of the HCQIA. To constitute a "professional review action" in the first place, a hospital must show that it based its peer review action on the physician's "competence or professional conduct . . . which conduct affects or could affect adversely the health or welfare of a patient or patients." 42 U.S.C. § 11151(9).

Congress did not intend this outcome. After careful debate of concerns raised by physicians and the public,[3]

---

3. *See, e.g.*, Report 99-103, Part I, Chairman Dingell, Committee on Energy and Commerce, H.R. Sep. 26, 1986; *cf* H.R. Rep. 99-903, pt. 1, at 21 (1986); Testimony of Sidney M. Wolfe, M.D., Director, Public Citizen Health Research Group, Oct. 6, 1986, House Judiciary Committee Hearings on H.R. 5540.

Congress decided a hospital could *never* make that showing if the decision was based primarily on one of the four exceptions, including competitive conduct and association with other classes of providers, such as osteopathic physicians, psychologists and others. Holding a hospital can avoid § 11151(9)'s carve-out if it reasonably believes that such association or certain competitive conduct would adversely affect patient welfare is to say that the statutory exceptions do not apply to any action that satisfies the general definition of a professional review action could qualify for the statutory exceptions. Under the Third Circuit's interpretation, the rule swallows the exception.

Just two years before passage of the HCQIA, in *Weiss v. York Hospital*, 745 F.2d 786 (3d. Cir. 1984), the Third Circuit affirmed an antitrust judgment against a Pennsylvania hospital for using its credentialing mechanism to exclude DOs as a class. As Congress debated exceptions to the immunities it was considering for hospitals, that case was part of the public record informing the debate. Whether the exclusion of osteopathic physicians was unlawful was subject to evidence and scrutiny by a court. However, with complete immunity, the hospital and its conspirators would not have been subject to scrutiny in the first instance. While peer review is important and hospitals should be generally immune, an exception was needed, and Congress provided it, with § 11151(9). Under the Third Circuit's analysis in the case below, there may well have been no *Weiss v. York Hospital*, and in that case discrimination against osteopathic physicians could continue to this day.

Similarly, the health care world is today locked in a competitive battle between the general acute care setting and specialized facilities that are sometimes owned and operated by the competitor of a hospital or certain of their closely allied physicians. (*See, e.g., Baptist Health v. Murphy, et al.*, 2006 Ark. Lexis 58, 2006 WL 242670 (Ark. Feb. 2, 2006)). Hospitals are using their credentialing mechanism to lock out competitors, sometimes defending their actions in the guise of their expansive view of what best furthers the delivery of quality care.

In these types of confrontations, hospitals have had to answer for their anticompetitive misconduct in a court of law and have not benefited from a blanket immunity never intended by Congress. If allowed to stand, the decision in the Third Circuit below creates just such an expanded immunity. A hospital's reasonable belief that its actions furthered quality healthcare would trump Congressionally mandated exceptions to immunity. These examples illustrate the wisdom of not tinkering with traditional rules of statutory construction, even assuming the set of facts the Third Circuit relied upon below.

The Supreme Court has consistently held that, as a fundamental matter of statutory construction, a statute should be read to give effect to all its parts, where possible. *E.g.*, *Cooper Industries, Inc. v. Aviall Services, Inc.*, 543 U.S. 157, 158 (2004); and *Duncan v. Walker*, 533 U.S. 167, 174 (2001). Here, the HCQIA can be read to give effect to both § 11151(9) and § 11112 if the "reasonable belief" requirement and presumption of § 11112 only applies after the court has determined, under § 11151, that an action is a "professional review action," which requires a determination that the action does not fall within one of the stated exceptions set forth in § 11151(9)(A)-(E). The Third Circuit did not address this logical and legal failing in its decision. No other court has construed these statutory sections like the Third Circuit did. The Court should grant certiorari to clarify how the law is to be read and to give effect to all its parts.

B. Words Are Not Read Into A Plain Statute.

The Third Circuit's decision effectively amends § 11112 to add that "it will be presumed that an action under § 11151(9)(A)-(E) is still a 'professional review action' if the action is taken with a reasonable belief it was done in furtherance of quality health care."

But §§ 11111, 11112 and 11151 do not say that. Rather, § 11151 defines a "professional review action" and identifies five exceptions (in § 11151(9)(A)-(E)) that are not considered to be based on competence or professional conduct and therefore are not "professional review actions." § 11112 then identifies how defined "professional review actions" must be taken and the presumptions that apply. Finally, § 11111 provides a limited immunity for damages for "professional review actions" as defined in § 11151 and taken in accordance with § 11112.

If Congress intended the immunity of § 11111 to apply to the exceptions identified in § 11151(9)(A)-(E) in situations where the review action was made with a reasonable belief it was furthering quality care, it easily could have expressed just that, as it did in § 11112. It did not. The inference and legal effect from Congress' failure to do so is clear. *See Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 452 (2002) (when Congress includes particular language in one section of a statute but omits it in another section of the same act, it is generally presumed that Congress acts intentionally and purposely in the disparate exclusion); *Id. K. P. Permanent Make-Up, Inc. v. Lasting Impression I, Inc.*, 543 U.S. 111, 118 (2004). Under the established rules of statutory construction, the Third Circuit's "reasonable belief" gloss cannot be applied to the enumerated exceptions to immunity of § 11151. The Court should grant Certiorari.

C. Even If HCQIA Was Not Clear On Its Face The Legislative History Directly Contravenes The Third Circuit's Decision.

The only way the Third Circuit could have read a "reasonable belief" gloss onto the exceptions of § 11151(9)(A)-(E) would have been to find the language ambiguous on its face and then rely on extrinsic evidence, such as the legislative history, to determine its meaning. Indeed, this is the very analysis the Third Circuit conducted with respect to the preamble language of § 11151:

> The plain language of the statute indicates the breadth of 'conduct' encompassed within the definition of 'professional review action'. . . .

Pet. App. 27. The Third Circuit also analyzed the preamble language in the alternative, assuming it was ambiguous, by looking to the legislative history. Pet. App. 27-28. But the Third Circuit failed to conduct that same analysis with respect to its interpretation of the exceptions in § 11151(9)(A)-(E). The meaning of those exceptions is just as plain as the "conduct" defined as "could affect adversely the health and welfare of a patient." Thus, the "reasonable belief" gloss should not have been applied to the exception. More importantly, the legislative history concerning the exceptions confirms the exceptions are absolute.

When HCQIA was debated, professional associations and the United States sought to assure that the proposed immunity of HCQIA would not empower hospitals to exclude classes of practitioners or inhibit competition. The Subcommittee on Civil and Constitutional Rights observed that with the increasing competitive pressures in the health care industry

> "peer review poses the risk of preventing or discriminating against other health providers from full economic participation in the marketplace, (which) is no different than any other illegal restraint of trade." *See* 132 Cong. Rec. H9954-01, 1986 WL 788373 (daily ed. Oct. 14, 1986) (statement of Rep. Edwards).

As a result of this concern, the Act contains exclusions: disciplining a physician for practicing with a DO (*See*, Exclusion 9(D)) or, as here, for competitive acts to solicit or retain business (*See*, Exclusion 9(B)). While a hospital could present evidence that it had a good faith belief, for instance, that a physician should not associate with a DO, it does not

receive HCQIA immunity when it disciplines a physician for doing so.[4]

Congressman Waxman made it clear during discussion of the HCQIA bill that the identified categories of § 11151(9)(A)-(E) were completely excluded from the protections of the Bill:

> I appreciate that any form of immunity raises defense concerns about the potential for mischief that might be visited by doctors on their colleagues for improper reasons . . . I am now convinced that we have addressed every legitimate objection that has been raised to the bill. As redrafted, our bill applies only to professional review actions based on the competence or conduct of an individual physician. *We completely exclude from the protections of the bill*, any disciplinary action based on a doctor's advertising . . .

Health Care Quality Improvement Act of 1986: Hearing on H.R. 5540 Before the Subcomm. on Civil Rights and Constitutional Rights of the Comm. on the House Judiciary, 99th Cong., 2d Sess. (1986) (statement of Hon. Henry A. Waxman, sponser of H.R. 5540) (emphasis added).

Mr. Dingell, in Committee hearings on the bill, confirmed Congress' intent to provide absolute exclusions for actions based on, *inter alia*, activities with regard to classes of health care practitioners. The "reasonable belief"

---

4. The Third Circuit noted below that one of the purposes of HCQIA was to improve the quality of medical care by restricting the ability of physicians who have been found to be incompetent from repeating malpractice by moving from state to state without discovery of such finding. App. 23; 42 U.S.C. § 11101. That purpose is not advanced in any way by the decision below reading a "reasonable belief" gloss onto the pro-competitive exceptions to the definition of a professional review action.

standard is not discussed nor otherwise raised in the entire legislative history of the act to avoid the effect of the exclusions:

> In addition, the Committee has carefully delineated circumstances which would not be considered to be based on competence or professional conduct. These include actions based on one's joining or not joining a professional society; on one's fees; on advertising or otherwise lawfully competing for business; on the economic organization of one's practice; or on one's activities with regard to health care practitioners who are not physicians . . . the Committee heard concerns from several groups that this area presented the greatest potential for abuse of the professional review process for economic or other reasons under the guise of improving the quality of health care. Accordingly, the Committee chose to restrict the protections under this legislation to actions by physicians against other physicians who do not meet reasonable tests of competence or professional behavior. **Professional review actions against physicians for reasons excluded from this legislation or those against other health care practitioners shall continue to be judged under all applicable law**.

H.R. Rep. No. 99-903, pt. 1, at 21 (1986) (emphasis added).

Certiorari should be granted to confirm there is no "reasonable belief" basis to void the exceptions to § 11151(9), and to effectuate Congress' clear intent.

II. CERTIORARI SHOULD BE GRANTED BECAUSE THE RULING BELOW IMPROPERLY SHIFTS THE BURDEN TO PLAINTIFFS TO ESTABLISH THE IMMUNITY DOES NOT APPLY.

In the decision below, the Third Circuit observed:

> Of course, as with *any challenge* to the applicability of immunity to a professional review action, the burden is on the physician to overcome the presumption that the hospital was engaged in a professional review action. 42 U.S.C. § 11112.

App. 32 (emphasis added).

This circular formulation misses the point that the question before the Court was whether this was a professional review action, as defined by Congress, at all. As significantly, it: contradicts established law that the burden is on the party raising an affirmative defense; suggests that all hospital review activities constitute "professional review actions" within the meaning of the statute and thus are entitled to a burden-shifting presumption of immunity; and threatens the very policies that Congress sought to achieve by establishing limits to hospital power through the exceptions enumerated in § 11151(9)(A)-(E).

A. Immunity is an affirmative defense, the burden of which is on the party raising it.

There can be little doubt that immunity is an affirmative defense, and as such, the burden of proving such a defense rests on the party raising it. *E.g.*, *K. P. Permanent Make-Up, Inc. v. Lasting Impression I, Inc.*, 543 U.S. 111, 120, 125 S. Ct. 542, 549 (2004); *Ironside v. Simi Valley Hosp.*, 103 F.3d 482, 484 (6th Cir. 1996); *Yeager's Fuel v. Pennsylvania Power & Light Co.*, 22 F.3d 1260, 1266 (3d Cir. 1994). By holding that in "*any challenge* (emphasis added) to the applicability of immunity to a professional review action,

the burden is on the physician to overcome the presumption that the hospital was engaged in a professional review action," the Third Circuit expressly contradicted this established rule of law, and created a conflict with the Court and other circuit decisions. App. 32.

For instance, under the Third Circuit's view, any time a physician challenges the suspension or revocation of medical staff privileges, a hospital would merely need recite that its actions are immune under § 11111(a) as "professional review actions" taken in furtherance of patient quality of care; the burden would then shift to the physician to prove by a preponderance of the evidence that the activity did not constitute a "professional review action" as defined in § 11151(9). On the contrary, established law requires that the hospital make a prima facie showing that it meets the requirements of § 11151(9) and does not fall within one of the five statutory exceptions enumerated in (A)-(E). Once the hospital offers proof that its actions constitute "professional review actions," it has met its initial burden in raising its affirmative defense of immunity. The physician then must overcome the hospital's initial showing by proving by a preponderance of the evidence, that the requirements of § 11112(a) have not been met, and thus the hospital is not entitled to immunity under the HCQIA.

The Third Circuit erroneously places the burden on the physician when it should be placed on the hospital pursuant to raising an affirmative defense of immunity from the physician's anti-trust challenges. The Third Circuit stands alone in its interpretation of HCQIA. No other circuit court has held that the burden is on the physician to prove that the hospital was not engaged in "professional review action" as defined in § 11151(9)(A)-(E). The Third Circuit's decision is contrary to established law and the plain language of a Congressional Act. Certiorari should be granted to address this split of authority and to clarify the burden of proof in HCQIA immunity.

B. There is no presumption in § 11151.

The Third Circuit also reads in additional terms not present in the plain language of the statute. By stating that "the burden is on the physician to overcome the presumption that the hospital was engaged in a professional review action," the Third Circuit effectively amends § 11151(9) to add that where a defendant hospital argues that an activity was made in furtherance of patient quality of care it will then be presumed that it did not fall within the exception of § 11151(9)(A)-(E). This interpetation is contrary to the plain language of the statute, the legislative history and statutory rules of construction.

As the presumption is provided only in § 11112(a) and states that if a "professional review action" (as defined in § 11151(9)) is taken, then it will be presumed to have been taken:

> (1) in the reasonable belief that the action was in furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of subparagraph (3).

The Third Circuit disregards the question of whether the hospital's actions in the first instance constitute a "professional review action" and instead applies the presumption in § 11112(a) to § 11151(9)(A)-(E). If

Congress had intended for the presumption under § 11112(a) to apply to a "professional review action" under § 11151(9), it would have expressed it as such. As discussed in section I.B. above, the inference and legal effect from Congress' failure to do so presumes that Congress excluded the presumption from the definition of a "professional review action" intentionally and purposely. *See Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 452 (2002); *K.P. Permanent Make-Up, Inc. v. Lasting Impression I, Inc.*, 543 U.S. 111, 118, 125 S. Ct. 542, 548 (2004).

By reading in a presumption that is not provided in the plain language of the statute, the Third Circuit has effectively read the exceptions provided in § 11151(9)(A)-(E) out of the HCQIA. As described in section I.C. above, the legislative history demonstrates that the exceptions were carefully drafted in order to exclude particular activities, such as associating with a particular class of health care provider or soliciting for business. These activities were expressly excluded from the definition of "professional review actions" because Congress determined they were too historically fraught with anticompetitive and political overtones to be a proper basis for reviewing the competence or professional conduct of a physician. In order for the statutory exceptions to be given effect, as intended by Congress, the Court should grant certiorari to clarify this issue.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be granted and the case held.

Respectfully submitted,

MARK E. RUST
Counsel of Record
DANIEL P. ALBERS
ELIZABETH M. BEDORE
BARNES & THORNBURG
One North Wacker Drive
Suite 4400
Chicago, Illinois 60606
(312) 357-1313

JOSHUA L. PROBER
General Counsel
AMERICAN OSTEOPATHIC ASSOCIATION
142 E. Ontario Street
Chicago, Illinois 60611

Counsel for Amici Curiae

MOTION FILED

MAR 1 3 2006

(3)

No. 05-1000

In The Supreme Court of the United States

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C.; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER, INC.,

Petitioners,

v.

LEWISTOWN HOSPITAL,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

MOTION TO FILE BRIEF AMICUS CURIAE AND BRIEF OF THE FEDERATED AMBULATORY SURGERY ASSOCIATION, THE AMERICAN ACADEMY OF OPHTHALMOLOGY, THE PENNSYLVANIA ACADEMY OF OPHTHALMOLOGY, THE AMERICAN COLLEGE OF SURGEONS AND THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

KATHERINE SALAZAR-POSS
General Counsel
AMERICAN ACADEMY OF OPHTHALMOLOGY
655 Beach Street
San Francisco, CA 94109
(415) 447-0359

Counsel for Amici Curiae

MICHAEL M. EATON
Counsel of Record
RONALD L. WISOR JR.
DAVID H. EVANS
DAVID C. ADKINS
ARENT FOX PLLC
1050 Connecticut Avenue NW
Washington, DC 20036
(202) 857-6000

MOTION TO FILE BRIEF *AMICUS CURIAE* OF THE FEDERATED AMBULATORY SURGERY ASSOCIATION, THE AMERICAN ACADEMY OF OPHTHALMOLOGY, THE PENNSYLVANIA ACADEMY OF OPHTHALMOLOGY, THE AMERICAN COLLEGE OF SURGEONS AND THE CALIFORNIA MEDICAL ASSOCIATION

The Federated Ambulatory Surgery Association (**FASA**), the American Academy of Ophthalmology (**AAO**), the Pennsylvania Academy of Ophthalmology (**PAO**), the American College of Surgeons (**ACOS**) and the California Medical Association (**CMA**) respectfully move for leave to file the attached *amicus curiae* brief, pursuant to Supreme Court Rule 37.2(b), in favor of granting the petition for a writ of *certiorari*.

FASA, a nonprofit organization, is the nation's largest ambulatory surgery center (**ASC**) association. ASCs are facilities where physicians perform surgeries that do not require hospital admission. FASA represents more than 1,800 ASCs nationwide, the physicians and other professionals who provide care in such centers and their patients.

AAO, a nonprofit organization, is the largest national membership association of ophthalmologists. AAO has approximately 28,000 members worldwide. More than 90 percent of practicing ophthalmologists are members of AAO. PAO, a nonprofit organization, is the membership association of ophthalmologists in Pennsylvania, with over 500 members. ACOS, a nonprofit organization, is a scientific and educational association of surgeons that was founded in 1913. Members of ACOS are referred to as "Fellows." The letters FACS (Fellow, American College of

Surgeons) after a surgeon's name mean that the surgeon's education and training, professional qualifications, surgical competence and ethical conduct have passed a rigorous evaluation and have been found to be consistent with the high standards established and demanded by ACOS. ACOS currently has more than 64,000 Fellows, including more than 3,700 Fellows in other countries and more than 5,000 Associate Fellows, making it the largest organization of surgeons in the world. CMA, a nonprofit organization, is California's largest medical professional association. CMA represents more than 30,000 physicians, in all specialties, practicing in California. Many of the members of AAO, PAO, ACOS and CMA have ownership interests or practice in ASCs, where they perform surgery as an extension of their office practices.

The members of FASA, AAO, PAO, ACOS and CMA are at the forefront of developing ASCs as cost-effective, high quality alternatives to hospital-based surgery. The first ASC opened in 1970. Today, more than 14 million surgeries are performed each year in over 4,500 ASCs. The vast majority of ASCs are owned by physicians, who invest in ASCs to obtain greater professional autonomy and control over their work environment and over the quality of care delivered to their patients.

ASCs offer improved technology, a non-institutional, friendly environment and more convenient locations, shorter wait times and lower patient coinsurance costs than their hospital competitors. U.S. Dep't of Justice & Federal Trade Comm'n, *Improving Health Care: A Dose of Competition (July, 2004)* (***Improving Health Care Report***). At the same time, ASCs save insurers and government health care programs billions of dollars by obtaining lower fees and avoiding costly hospitalizations. A recent study of Medicare claims commissioned by FASA found that, on

average, claims cost $320 less in an ASC compared to hospital outpatient settings, and that the procedures performed in ASCs cost the Medicare program $1.1 billion less in 2005 than if the same procedures were performed in a hospital. Federated Ambulatory Surgery Association, *Medicare Payments for Procedures Performed in Ambulatory Surgery Centers Compared with Hospital Outpatient Departments* (Apr. 5, 2005), http://www.fasa.org/april5execsum.pdf. By providing a competitive alternative to hospitals, ASCs "enhance quality of care, lower prices, and improve access." *Improving Health Care Report,* Ch. 3 at 39-40.

FASA, AAO, PAO, ACOS and CMA urge the Court to grant the petition for a writ of *certiorari* to address two aspects of the Third Circuit's decision. First, this case squarely presents the question whether an entity must actually sell goods or services in the same relevant market to be a competitor under the Sherman Act. An entity does not have to sell goods or services in the same relevant market to be a competitor under the Sherman Act. By limiting the availability of the Sherman Act's protections to actual competitors, the Third Circuit has effectively immunized antitrust conspirators and monopolists for anticompetitive activities so long as their competitor has not yet opened. As a consequence of the Third Circuit's holding, incumbents will find it far easier to quash new entry and to sustain market power. Prices will increase, and quality will decrease. It is often the potential entrant that needs the most protection. ASCs are frequently the entities most likely to enter a market in competition with an entrenched, incumbent hospital and are frequently the target of exclusionary practices by those very hospitals. ASCs are therefore particularly vulnerable to this decision.

The Third Circuit is alone in concluding that potential competitors are not subject and entitled to Sherman Act prohibitions and protections. No other Circuit, including the Third Circuit up until this case, refuses to extend Sherman Act prohibitions and protections to potential competitors. This Court should grant the petition for a writ of *certiorari* to make clear that an entity does not have to sell goods or services in the same relevant market to be a competitor under the Sherman Act. Because FASA, AAO, PAO, ACOS and CMA represent a broad spectrum of ASCs and their affiliated physicians and other professionals, their perspectives on this issue should be helpful to the Court.

Second, this case raises the question whether a restraint on a physician's ability to disseminate truthful and non-deceptive information about his principal competitor can constitute a substantial effect on competition. The dissemination of truthful and non-deceptive information is critical to the efficient operation of health care markets. Restraints that limit the ability of physicians to disseminate such information have a significant effect on the ability of patients to choose optimal treatments for their illnesses and can cause significant market inefficiency or failure. The information restraints in this case, as written and as read by the Third Circuit, would have a substantial effect on competition. The Third Circuit is in conflict with this Court's decision in *California Dental Ass'n v. F.T.C.*, 526 U.S. 756 (1999) and the Ninth Circuit in *California Dental Ass'n v. F.T.C.*, 224 F.3d 942 (9th Cir. 2000). This Court should grant the petition for a writ of *certiorari* to make clear that information restraints that limit the ability of physicians to disseminate truthful and non-deceptive information, such as the ones in this case, do have a substantial effect on competition meriting a full consideration by the court and requiring strong

procompetitive justifications to sustain the restraints. Because FASA, AAO, PAO, ACOS and CMA represent a broad spectrum of physicians, their perspectives on this issue should be helpful to the Court.

In accordance with Supreme Court Rule 37.2, FASA, AAO, PAO, ACOS and CMA represent that they obtained written consent from counsel for the petitioners to file this brief *Amicus Curiae*. Counsel for the respondent declined to consent, however, thereby necessitating this motion. Sup. Ct. R. 37.2(b).

For these reasons and those set out in the accompanying brief, FASA, AAO, PAO, ACOS and CMA hereby move the Court to allow them to appear as *Amici Curiae* and to submit their brief urging the Court to grant the petition and reverse the decision of the Court of Appeals for the Third Circuit.

Respectfully submitted,

MICHAEL M. EATON
Counsel of Record
RONALD L. WISOR JR.
DAVID H. EVANS
DAVID C. ADKINS
ARENT FOX PLLC
1050 Connecticut Ave., NW
Washington, DC 20036
(202) 857-6000

KATHERINE SALAZAR-POSS
General Counsel
AMERICAN ACADEMY OF
OPHTHALMOLOGY
655 Beach St.
San Francisco, CA 94109
(415) 447-0359

Counsel for Amici Curiae

March 13, 2006

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES vi

STATEMENT OF INTEREST 1

STATEMENT OF THE CASE 1

REASONS FOR GRANTING THE PETITION 3

I. THE SHERMAN ACT'S PROHIBITIONS AND PROTECTIONS APPLY TO POTENTIAL COMPETITORS LIKE ASCs 4

A. The Sherman Act Applies to both actual and potential competitors. 4

B. An entity must possess the intent and ability required to compete to be a potential competitor 8

II. THE INFORMATION RESTRAINTS MAY HAVE A SUBSTANTIAL EFFECT ON COMPETITION 11

CONCLUSION 15

TABLE OF AUTHORITIES

FEDERAL CASES

Case ***Page***

American Motor Inns, Inc. v. Holiday Inns, Inc., 521 F.2d 1230 (3d Cir. 1975) 5

American Tobacco Co. v. United States, 328 U.S. 781 (1946) 7

California Dental Ass'n v. F.T.C., 526 U.S. 756 (1999) 11, 12

California Dental Ass'n v. F.T.C., 128 F.3d 720 (9th Cir. 1997), *rev'd*, 526 U.S. 756 (1999) 12

California Dental Ass'n v. F.T.C., 224 F.3d 942 (9th Cir. 2000) 12, 14

Engine Specialties v. Bombardier, 605 F.2d 1 (1st Cir. 1979) 5

Evans v. S.S. Kresge Co., 544 F.2d 1184 (3d Cir. 1976) 5

F.T.C. v. Indiana Federation of Dentists, 476 U.S. 447 (1986) 11

Fishman v. Estate of Wirtz, 807 F.2d 520 (7th Cir. 1986) 7

In re Cardizem CD Antitrust Litigation,
332 F.3d 896 (6th Cir. 2003), *cert. denied sub nom. Andrx Pharmaceuticals, Inc. v. Kroger Co.*,
543 U.S. 939 (2004) 6, 7

In re Terazosin Hydrochloride Antitrust Litigation,
352 F. Supp. 2d 1279 (S.D. Fla. 2005) 6, 8

LePage's Inc. v. Minnesota Mining & Mfg. Co., 324 F.3d. 141 (3d Cir. 2003), *cert. denied*,
542 U.S. 953 (2004) 7

Otter Tail Power Co. v. United States,
410 U.S. 366 (1973) 5

Palmer v. BRG of Georgia, 498 U.S. 46 (1990) 5

SmithKline Corp. v. Eli Lilly & Co., 575 F.2d. 1056 (3d Cir.), *cert. denied*, 439 U.S. (1978) 7

Transource International, Inc. v. Trinity Industries,
725 F.2d 274 (5th Cir. 1984) 8

United States v. Columbia Pictures Corp.,
169 F. Supp. 888 (S.D.N.Y. 1959) 5

United States v. MMR Corp., 907 F.2d 489 (5th Cir. 1990) 8

United States Philips Corp. v. Windmere Corp.,
861 F.2d 695 (Fed. Cir. 1988) 7

United States v. Reicher, 983 F.2d 168 (10th Cir. 1992) 8

United States v. Topco Associates, Inc.,
405 U.S. 596 (1972) 4, 5

Virginia Health Board of Pharmacy v. Virginia Citizens Council, 425 U.S. 748 (1976) 11

Wallace v. Free Software Foundation, Inc.,
2005 WL 3239208 (S.D. Ind. Nov. 28, 2005) 7

FEDERAL RULES

Rule Cited ***Page***

Supreme Court Rule 37.6 1

OTHER AUTHORITIES

Page

U.S. Dep't of Justice & Federal Trade Comm'n, *Improving Health Care: A Dose of Competition* (July, 2004) 9, 10, 11

U.S. Dep't of Health and Human Services, *Payment for Procedures in Outpatient Departments & Ambulatory Surgical Centers* (Jan., 2003) 10

Federated Ambulatory Surgery Association, *Medicare Payments for Procedures Performed in Ambulatory Surgery Centers Compared with Hospital Outpatient Departments* (Apr. 5, 2005), http://www.fasa.org/april5execsum.pdf 10

STATEMENT OF INTEREST[1]

The Statement of Interest of the Federated Ambulatory Surgery Association (**FASA**), the American Academy of Ophthalmology (**AAO**), the Pennsylvania Academy of Ophthalmology (**PAO**), the American College of Surgeons (**ACOS**) and the California Medical Association (**CMA**) are included in the Motion to File. FASA, AAO, PAO, ACOS and CMA have no interest in any party to this litigation or stake in the outcome of the case.

STATEMENT OF THE CASE

FASA, AAO, PAO, ACOS and CMA adopt the Statement of the Case presented by the petitioner. Pet. at 3-9. The petitioners consist of an ophthalmologist, Dr Alan Gordon (**Gordon**), his professional corporation, Dr. Alan Gordon M.D., P.C., and the surgical facility, Mifflin County Community Surgical Center, Inc. (**MCCSC**), he was attempting to open. The respondent is Lewistown Hospital (the **Hospital**), the incumbent, and only, hospital in Mifflin and Juniata counties in Pennsylvania. Gordon and another ophthalmologist, Dr. Paul Nancollas (**Nancollas**), were the only two ophthalmologists in Mifflin and Juniata counties. Pet. at 3. Both had privileges at the Hospital. On several occasions, Gordon was critical of Nancollas. The Hospital was concerned about Gordon's criticism. To suppress that criticism, the Hospital imposed certain restrictions on Gordon. These restrictions included information restraints

---

[1] Pursuant to Supreme Court Rule 37.6, FASA, AAO, PAO, ACOS and CMA state that this brief has not been authored in whole or in part by counsel for a party and that no person or entity, other than Amici, their members or their counsel, has made a monetary contribution to the preparation or submission of this brief.

that barred Gordon from discussing the differences between him and Nancollas with patients:

> (2) ...[A] complaint or concern about any other member of the Medical-Dental Staff must be in writing addressed to either the President of the Medical Staff or the Chairperson of the Hospital, with a copy to the President of the Hospital...
>
> (3) You shall not call, or otherwise attempt to communicate with, the patients of any other ophthalmologist, or other physician practicing in the Hospital, for the purpose of commenting on the physician's training, skill or competence or the procedure performed by such physician. Furthermore, other than in response to a specific question or for the purpose of a referral, you shall not make any comment about any other ophthalmologist as part of your discharge instructions or at any time when dealing with patients who have been or will be treated at the Hospital.

App. at 10-11. The Hospital required Gordon to adopt the conditions to maintain his privileges at the Hospital. He required privileges or a transfer agreement with the Hospital to open MCCSC. App. at 83. Gordon was planning to open MCCSC at the time the information restraints were imposed. The Hospital knew he was trying to open MCCSC. *E.g.*, App. at 15.

The petitioners sued the respondent for violations of Sections 1 and 2 of the Sherman Act. App. at 2. Count I of the petitioners' complaint alleged that the information restraints constituted an unreasonable restraint of trade under Section 1 because they prevented Gordon from